



Contents lists available at ScienceDirect

Journal of Professional Nursing

journal homepage: www.elsevier.com/locate/jpnu

Building a Child Mental Health Workforce for the 21st Century: Closing the Training Gap^{☆, ☆, ☆}



Kathleen R. Delaney^{a,*}, Niranjan S. Karnik^b

^a *Psychiatric Mental Health Nurse Practitioner Program, Rush College of Nursing, Department of Community, Systems and Mental Health, 600 S. Paulina St, Chicago, IL 60612, United States of America*

^b *Department of Psychiatry, Section on Population Behavioral Health, Department of Psychiatry, Rush University Medical Center, 1645 West Jackson Blvd., Suite 302, Chicago, IL 60612, United States of America*

ARTICLE INFO

Keywords:

Interprofessional education
Child mental health
Fellowship training
Community based training

ABSTRACT

Of the children and adolescents with mental health concerns who receive treatment, most do so in outpatient community mental health service sites, systems of care which have largely failed to produce significant clinical outcomes. Suggested strategies to improve care in child mental health treatment include improving families' access to services, increasing use of evidence-based practices (EBPs), and holding service sites accountable for demonstrating outcomes. Producing a workforce to implement these strategies will require cultivating providers who have developed specific competencies within a range of agencies that naturally interface with the daily lives of families and their children. The authors report on a recently developed interprofessional child community fellowship for psychiatry residents and psychiatric mental health nurse practitioners aimed at training providers to deliver child mental health services in a variety of community settings. Activities that focus the fellowship are outlined along with the development of the related competencies: EBP translation, collaboration skills, and outcome measurement. Evaluation strategies for fellows' competency development are discussed.

Introduction

Tragically, 13–20% of children have a diagnosable mental health problem yet the majority (nearly two-thirds) get little or no help (CDC, 2013). The rates of mental health problems are even higher for youth in foster care, juvenile justice and emergency shelters (Coulomb, 2017; Gattis & Larson, 2016; Perlman, Willard, Herbers, et al., 2014; Traube, James, Zhang, & Landsverk, 2012) and for these children trauma exposure is an all too familiar thread in their mental distress (Jackson Foster, Phillips, Yabes, et al., 2015; Wong, Clark, & Marlotte, 2016). In the midst of tremendous need, child mental health services operate as a flawed system; fraught with access issues, lack of providers, and poor family service engagement (AACAP, 2014; Cummings, Wen, & Druss, 2013; Haine-Schlagel & Walsh, 2015). The effectiveness of mental health care is also an issue; data indicate that children receiving treatment in community-based mental health centers have about the same outcomes as those who do not receive specialty services (Garland, Haine-Schlagel, Accurso, et al., 2012; Weisz, Kuppens, Eckshtain, et al., 2013).

To create systems that improve access, increase family engagement,

and promote child mental well-being, services must be brought to the community and to organizations that serve children, including schools, pediatric health centers, juvenile justice and child protection agencies (Kazak, Hoagwood, Weisz, et al., 2010). Providers' mindset for addressing behavioral problems must be informed by evidence based practices (EBPs) but also the role of communities in building youth resiliency (Bolger Center for Leadership Development, 2013). To implement a meta-systematic orientation will demand providers who focus on these structural elements of care and efficient use of inter-professional teams, a shift which will require providers to take on an approach that moves away from traditional office-based psychiatry (McCarron, Bourgeois, Chwastiak, et al., 2015).

Unfortunately, most mental health workforce education lags behind this vision for systems change. Producing a workforce to implement these strategies will require a new mindset around provider education. This paper reports on the organizing framework for the child component of an interprofessional Community Psychiatry Fellowship Program; a fellowship where the overarching structure of the program is designed to educate providers with specific competencies that naturally interface with the daily lives of families and their children.

[☆] The authors have no conflicts of interest to report.

^{☆☆} There was no funding support for this paper.

* Corresponding author.

E-mail addresses: Kathleen_R_Delaney@rush.edu (K.R. Delaney), Niranjan_Karnik@rush.edu (N.S. Karnik).

Training will build on an ecological perspective of children; where mental health issues are seen as nested in the environments that support the child. The frame of the residency aligns with Bronfenbrenner's (1999) ecological model of child development which maps the interaction between the child and elements within her/his environment. The model considers multiple factors from biological determinants (e.g. genetics) to family and broader social institutions, all of which interact to influence the child's development and mental health.

Detailed below is how a proposed training model moves students' mindset towards an ecological perspective. Next, practical elements of establishing the fellowship are discussed along with the proposed fellowship competencies and planned strategies to develop these students' skills. The paper concludes with methods to evaluate fellows' competency development in each realm, evidence-based practice, collaboration skills, and outcome measurement.

How the model shifts training to an ecological perspective

Unfortunately, unless education changes, the gap will grow wider between how the child mental health workforce approaches treatment and advocates' vision of child well-being (RWJ Foundation & Ashoka, 2016). Education for providers, such as psychiatrists and psychiatric mental health nurse practitioners (PMH NPs), concentrates on isolating a child's diagnosis which then provides the basis for treatment-with scant consideration of risk/protective factors embedded in the broader contexts in which the youth lives (Frameworks Institute, 2010). This office-based training yields a family-by-family treatment plan that often fails to incorporate the environmental/social factors that influence the child's mental health or to consider how to strengthen school and community supports to build resiliency. It is an approach that sets trainees towards a solo practice or working as an independent provider with larger groups. There is scant interface with evolving team-based models which are critical to improving access to care and to fostering collaboration with primary care settings where children and families naturally interface (National Council, Medical Directors Institute, 2017).

To cultivate providers that will effectively address 21st century issues also demands a shift from traditional training focused on tertiary care. Evidence supports that decreases in vulnerable youths' behavioral symptoms can be achieved via the development of family connections, school support and strengthening community ties (Gattis, 2013, 2014; Stoner, Leon, & Fuller, 2015). Thus, education of providers must attend with equal vigor to emotional illnesses which create serious impairment and to prevention efforts that support children's healthy development (Behrens, Lear, & Price, 2013; Delaney, 2015). Providers' training also demands an approach to the complex associations between trauma, social displacement, and risk for mental health issues (Petering, 2016; Weder, Zhang, Jensen, et al., 2014). Producing a workforce to implement these changes will require specific training strategies.

Proposed interprofessional child mental health fellowship

This project situated within Rush Department of Psychiatry will launch in fall of 2018 and initiate interprofessional teams of psychiatry residents, advanced psychiatry fellows and PMH NPs. Training is planned in a variety of community settings (youth homeless shelters, community organizations, and school-based clinics) so that trainees begin to apprehend the situations underlying mental health distress especially for vulnerable youth. Prior to the development of the fellowship, the Departments of Nursing and Child Community Psychiatry had built a strong relationship around their joint membership on students' dissertations and DNP projects as well as collaboration in developing NP roles in various department initiatives. Perhaps because of these interconnections, the fellowship idea met little resistance from the administration or faculty of either department.

The fellowship calls for interprofessional community-based training.

The physician fellowship is one year in alignment with community and public psychiatry fellowships across the country (Osofsky, Speier, Hansel, et al., 2016; Alonso, Jardon, Pizarro, et al., 2017). The PMH NP fellowships will be structured as a six-month longitudinal experience with the team which will occur at the end of the PMH NP student's clinical practicum year. This timing and placement schedule owes to the sustained support that will be needed to maintain the fellowship. PMH NPs are licensed and certified to provide the full range of mental health services across the lifespan, include prescribing psychotropic medications (Delaney, 2017). Training these two groups of practitioners as a team increases the workforce but also the synergistic capabilities of providers to work as a team (Schwartz, O'Laughlen, & Kim, 2017).

The community psychiatry fellowship is an important step towards building a workforce that addresses serious mental illness and prevention with equal urgency and views mental health issues within the context of the community that supports the child's development. For example, all trainees in this program will be trained in the UCLA-developed model Families OverComing Under Stress (FOCUS) which is a family-and group-based treatment model for military families now being adapted for broader implementation in trauma-exposed populations (Lester, Liang, Milburn, et al., 2016). The fellowship advances a training model that does not base treatment solely on a Diagnostic and Statistical Manual (DSM) driven diagnostic process but considers strength-based approaches grounded in the context of the life the child lives.

The interprofessional team training builds fellows' collaboration skills which are necessary for the health care teams that will increasingly deliver child mental health services (National Council, 2017). The teams will be formed by the fellowship group and their advisors (MDs/NPs) as well as mental health professionals at the community site. They will learn how to function with care coordinators and orient to their role in collaborative care models (Raney, Lasky, & Scott, 2017). Within schools and specialty settings fellows will experience how effective teams function to assure each member is practicing to the top of their license and training (Delaney, Naegle, Valentine, et al., 2017).

Finally, the fellows will be trained in prevention, screening, early intervention and effective referral. Proposed methods for treatment planning include a structure for incorporating social determinants of health and the family narrative into the initial formulation. The broad goal of the fellowship is to increase the number of Psychiatrists and PMH NPs with competencies to address the needs of children with complex behavioral health issues within the context of community settings. Given the training structure and goals, the specific outcomes of the fellowship are organized into three clusters of competencies: EBP translation, collaboration skills, and outcome evaluation. These competencies are outlined in Table 1 and elaborated in the next three sections.

Cluster one: competencies at EBP translation

To develop an EBP focus which incorporates social determinants of health several educational strategies will be used. The fellows will consistently use resources pages that list evidence based programs and practices (e.g. <https://prevention.nih.gov/resources-for-researchers/dissemination-and-implementation-resources/evidence-based-programs-practices#topic-6>) and review research to substantiate EBPs. To increase understanding of EBP's structure, students will train in modalities like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Screening, Brief Intervention & Referral to Treatment (SBIRT); and Families OverComing under Stress (FOCUS). Training will occur in settings including youth homeless shelters where fellows will implement resiliency models, particularly relatively brief intervention programs that have shown to be effective (Rew, Powell, Brown, et al., 2017).

To put EBPs into practice, in initial stages of treatment planning, the

Table 1

Proposed outcomes of the child track of the community psychiatry fellowship.

Cluster one: Competencies in EBP translation
1. Fellows demonstrate proficiency at providing community-based, evidence-based mental health services.
2. Fellows develop competencies in prevention strategies, particularly proficiency in screening and using referral networks.
3. Fellows consistently incorporate social determinants of health and the unique needs of vulnerable populations in their treatment formulations and planning.
Cluster two: Competencies related to collaboration
4. Fellows demonstrate interprofessional abilities and increased readiness to function as part of a health care team.
5. Fellows demonstrate collaboration skills with primary care and community sites via use of tele-psychiatry
6. Fellows employ principles of family collaboration in treatment planning and systems of care development
Cluster three: Competencies related to outcomes
7. Fellows utilize quality improvement strategies to address emerging care issues particularly around service outcomes.
8. Fellows participate in initiatives to collect behavior, symptom or well-being measures, track improvement and develop strategies for non-response to treatment.
9. Fellows apply evidence-based strategies to achieve improvements in family engagement in care and child outcomes.

team will build decision trees which incorporate appropriate choices of evidence-based approaches. Via these EBP decision trees fellows will parse out provider roles but also articulate their disciplinary perspective on a youth's situation, i.e., how does a particular provider group approach this child's situation given their disciplinary lens? This approach acknowledges that disciplines have a way of looking at the world that influences the questions they ask and how teaching within that discipline is pursued (Repko, Szostak, & Buchberger, 2016). While some providers may gravitate towards viewing a child via symptom profiles, other professions may focus on developing a sense of the life child lives; for example, the strategies underserved adolescents may use to survive violence while negotiating the economic, race and socio-cultural factors that impact their lives (McIntyre, 2000). The conversations that revolve around these diagnosis-specific EBP decision trees capture these perspectives and inform the interprofessional approach.

This approach will also incorporate the social determinants of mental health; the social and environmental factors that account for unequal distribution of opportunity and one of the driving forces behind risk (Compton & Shim, 2015). The determinants Compton and Shim delineate (such as adverse life experiences, poor education, poverty, and neighborhood deprivation) are often evident in the lives of children with mental health issues. To structure the dialog around social determinants, the team will use a Perspectives of Psychiatry training format which maps a treatment formulation inclusive of the multiple factors that play into a child's mental health distress, their life narrative, how they currently cope and the community/school supports that need to be in place to achieve optimal well-being (McHugh & Slavney, 2009). Included will be the parent or guardian's ideas on the child's problem which is a particularly important perspective that informs on the child's life and needs. Thus, the approach to building competencies combines EBP decision trees along with a process for case formulation that naturally incorporates culture and social determinants of health.

Cluster two: competencies around collaboration skills

The fellowship will also focus on developing competencies in screening, building teams to support referrals, and collaboration skills with both primary care and community sites. The broad implementation of integrated care brings with it need for training in specific competencies around formulating a consultation on health behavior

change and a holistic approach to care (Croze, 2015; Ratzliff, Norfleet, Chan, et al., 2015; Reardon, Bentman, Cowley, et al., 2015); a disciplinary perspective that fits well with nurses' training and care coordination expertise (Delaney, Robinson, & Chafetz, 2013).

Our Departments of Psychiatry and Community/Systems and Mental Health Nursing have considerable expertise in Screening, Brief Intervention and Referral to Treatment (SBIRT), having completed a 3-year project on interprofessional SBIRT training. The Department of Psychiatry has several ongoing projects around screening and referral which we will utilize to train fellows in "the next steps" in screening initiatives, i.e., development of decision algorithms for treatment and referral and building appropriate resources. There is considerable interest in using SBIRT with adolescents (Yuma-Guerrero, Lawson, Velasquez, et al., 2012) but the effectiveness of brief interventions (BI) remains under researched (Mitchell, Gryczynski, O'Grady, et al., 2013). These considerations will inform how the fellows implement BI modalities, particularly in the school setting.

It is widely accepted that given the shortage of mental health providers, telepsychiatry is a viable means for increasing access to care (Shore, 2013). Use of telepsychiatry in child mental health is demonstrating significant outcomes for the children served (Hilt, Barclay, Bush, et al., 2015). Thus skills considered essential for beginning practitioners which will be incorporated in practice with a tele psychiatry system that is being employed by the Rush Department of Psychiatry.

Cluster three: skills at outcome measurement

Finally, the program will focus on developing fellows' competencies on evaluation of services, client outcomes and implementation of measurement based care. While measurement based care is not new it is coming to the fore as a key component of integrated care (Kroenke & Unutzer, 2017). In child mental health standardized benchmarks for gauging treatment response are beginning to emerge, such as the use of the Screen for Child Anxiety Related Disorders (SCARED) to assess gains and gauge treatment effectiveness with anxiety conditions (Caporino, Sakolsky, Brodman, et al., 2017). Fellows will apply the basics of measurement based care to a population within a select site and determine the next level of care for any child for whom the intensity/level of care is yielding an inadequate treatment response.

System's outcomes will also be considered through the fellows' participation in quality improvement (QI) projects aimed at improving site-specific processes or outcomes. The fellows' experiences with QI methods will build on the partnership with the site administration and if present, consumer/community advisory panel. Fellows will receive specific instruction on QI skills using a problem based learning format (Kataoka, Podell, Zima, et al., 2014); nursing fellows will augment quality improvement skills acquired during their Doctor of Nursing (DNP) program (AACN, 2006).

While the focus of the quality project will be determined by the site, one area of careful scrutiny will be families' service engagement. Significant issues exist around family engagement both at initial intake and follow-up session attendance (Gopalan, Goldstein, Klingenstein, et al., 2010). Research is emerging however around approaches to increase families' service engagement (Haine-Schlagel & Walsh, 2015; Ingoldsby, 2010) and fellows will work within the service site to explore strategies to involve families in care. Emphasis will be on the critical nature of the relationship with the family and understanding their perspective, developing treatment goals with families and data-based monitoring on progress toward those goals (Lindsey, Brandt, Becker, et al., 2014; Warnick, Bearss, Weersing, et al., 2014). Fellows will also employ family advocates and utilize strength-based approaches which have been successful in state wide initiatives, such as New York Parent Empowerment Project (Olin, Hoagwood, Rodriguez, et al., 2010). The emphasis will be creating cultures which invite service engagement and outcomes that focus on the strength of the

collaborative relationship.

Evaluating the success of the fellowship

Several mechanisms will be utilized to evaluate the fellowship. As gauged by validated interprofessional education measures, fellows will demonstrate proficiency at interprofessional competencies e.g. acquisition of the skills linked to interprofessional collaboration; understanding other health professionals' roles and responsibilities; and development of teamwork skills (Archibald, Trumppower, & MacDonald, 2014). Fellows' multidisciplinary collaboration skills, particularly within integrated care experiences will also be assessed (Olupeliyawa, O'Sullivan, Hughes, et al., 2014). Teams of fellows will complete a proposal aimed at building a prevention approach to a select child/adolescent population including an algorithm for symptom thresholds and referral. Each fellow will conduct a case conference using a Perspectives of Psychiatry training format during which he/she will map treatment approaches inclusive of the multiple factors that play into a child's mental health distress and the community/school supports that need to be in place to achieve optimal well-being.

Fellows will work with a select training site (school based clinic, community mental health site, homeless shelter) to devise a quality improvement project aimed at an identified issue, considering local capacity and resources, and what the setting aims to achieve (Atkins, Rusch, Mehta, et al., 2016). Fellows will use consumer/family feedback to rate their own efforts at collaboration particular via review of family expectations and their subsequent response (Rowe, 2014). Finally, the preceptors will evaluate fellows' knowledge and skills around strategies to enact measurement based care in community clinics.

Discussion

Initiation of these fellowships is critical to building the child mental health workforce. Psychiatry and nursing programs interested in collaborations should begin by building a relationship base between the departments. Once the leaders of these departments have a clear sense of what needs to be accomplished within the community, the next step is establishing community partnerships with organizations interested in building collaborative models of service delivery. Funding these fellowships is a significant issue. Physicians have access to the federally supported Graduate Medical Education system. Nursing which has no such federal support. Institutions have supported nursing fellowships in specialty areas of particular need (Rugen, Dolansky, Dulay, et al., 2018). In 2017 HRSA did award grants for Behavioral Health Fellowship training and the continuation of these initiatives is vital to the growth of mental health workforce. Minus this type of support, funds for nursing fellows need to be secured largely through philanthropy.

The significant unmet mental health needs of children, adolescents and families in the U.S. require innovative staffing and training models. By placing providers in community contexts and establishing consultation models with proven effectiveness, this fellowship program provides a natural platform for increasing community-based child mental health and interprofessional skills of both MDs and PMH NPs. The health care system is changing in ways that demand multidisciplinary collaboration using evidence-based models of care. In this paper one approach to these challenges has been outlined; the creation of community psychiatry fellowship program with a child training track. Such a multidisciplinary training model will create a context for developing a workforce of the future; one in which disciplines collaborate for best outcomes.

References

Alonso, M., Jardon, M., Pizarro, M., et al. (2017). The community value of academic psychiatry: The development of a psychiatry residency program in a federally qualified health center. *Academic Psychiatry, 41*(1), 1–6.

- American Academy of Child and Adolescent Psychiatry. AACAP work force fact sheet. (2014). Retrieved from: http://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/workforce_issues/workforce_factsheet_2014.doc (Accessed June 1, 2017).
- American Association of Colleges of Nursing. *The essential of doctoral education for advanced nursing practice.* (2006). Retrieved from <http://www.aacn.nche.edu/dnp/Essentials.pdf> (Accessed on July 1, 2017).
- Archibald, D., Trumppower, D., & MacDonald, C. J. (2014). Validation of the interprofessional collaborative competency attainment survey (ICCAS). *Journal of Interprofessional Care, 28*(6), 553–558.
- Atkins, M. S., Rusch, D., Mehta, T. G., et al. (2016). Future directions for dissemination and implementation science: Aligning ecological theory and public health to close the research to practice gap. *Journal of Clinical Child and Adolescent Psychology, 45*(2), 215–226.
- Behrens, J., Lear, J. G., & Price, O. A. (2013). *Improving access to children's mental health care: Lessons from a study of eleven states.* Center for Health and Health Care in Schools, George Washington University. Retrieved from http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1066&context=sphhs_prev_facpubs (Accessed on May 1, 2017).
- Bolger Center for Leadership Development. *Healthy development summit II: Changing frames and expanding partnerships to promote children's mental health and social/emotional wellbeing.* (2013). Retrieved from <http://www.apa.org/pi/families/healthy-development.aspx> (Accessed on June 1, 2017).
- Bronfenbrenner, U. (1999). Environments in developmental perspective: Theoretical and operational models. In S. L. Friedman, & T. D. Wachs (Eds.). *Measuring environment across the life span: Emerging methods and concepts* (pp. 3–28). Washington, DC, US: American Psychological Association.
- Caporino, N. E., Sakolsky, D., Brodman, D. M., et al. (2017). Establishing clinical cutoffs for response and remission on the screen for child anxiety-related emotional disorders (SCARED). *Journal of the American Academy of Child and Adolescent Psychiatry, 56*(8), 696–702.
- CDC (2013). MMWR, mental health surveillance among children, United States, 2005–2011. 62(02), 1–35. Retrieved from: <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm> (Accessed June 1, 2017).
- Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus, 13*(4), 419–425.
- Coulomb, A. (2017). Mental health of adolescents in foster care: A literature review. *Journal of Undergraduate Social Work Research, 1*.
- Croze, C. *Health care integration in the era of the affordable care act.* (2015). Retrieved from <http://abhw.org/publications/pdf/IntegrationPaper.pdf> (Accessed on January 1, 2017).
- Cummings, J. R., Wen, H., & Druss, B. G. (2013). Improving access to mental health services for youth in the United States. *Journal of the American Medical Association, 309*(6), 553–554.
- Delaney, K. R. (2015). Why do we need a child mental health specialty? *Journal of Child and Adolescent Psychiatric Nursing, 28*, 1–2.
- Delaney, K. R. (2017). Psychiatric Mental Health Advanced Practice Nursing Workforce: Capacity to address mental health professional workforce shortages. *Psychiatric Services.* <http://dx.doi.org/10.1176/appi.ps.201600405> (PS in Advance, May 15, 2017).
- Delaney, K. R., Naegle, M. A., Valentine, N. M., et al. (2017). The effective use of psychiatric mental health nurses in integrated care: Policy implications for increasing quality and access to care. *The Journal of Behavioral Health Services & Research, 1–10* (First online May 8, 2017).
- Delaney, K. R., Robinson, K. M., & Chafetz, L. (2013). Development of integrated mental health care: Critical workforce competencies. *Nursing Outlook, 61*(6), 384–391.
- Frameworks Institute. *From individual to community: Changing the culture of practice in children's mental health. An interview with Ron Manderscheid.* (2010). Retrieved from http://www.frameworksinstitute.org/assets/files/PDF/interview_with_ron_manderscheid.pdf (Accessed on May 1, 2017).
- Garland, A. F., Haine-Schlagel, R., Accurso, E. C., et al. (2012). Exploring the effect of therapists' treatment practices on client attendance in community-based care for children. *Psychological Services, 9*(1), 74–88.
- Gattis, M. N. (2013). An ecological systems comparison between homeless sexual minority youths and homeless heterosexual youths. *Journal of Social Service Research, 39*(1), 38–49.
- Gattis, M. N. (2014). Are family communication and school belonging protective factors against depressive symptoms in homeless youth in Toronto? *Canadian Journal of Community Mental Health, 32*(4), 75–83.
- Gattis, M. N., & Larson, A. (2016). Perceived racial, sexual identity, and homeless status-related discrimination among black adolescents and young adults experiencing homelessness: Relations with depressive symptoms and suicidality. *The American Journal of Orthopsychiatry, 86*(1), 79–90.
- Gopalan, G., Goldstein, L., Klingenstein, K., et al. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*(3), 182–196.
- Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review, 18*(2), 133–150.
- Hilt, R. J., Barclay, R. P., Bush, J., et al. (2015). A statewide child telepsychiatry consult system yields desired health system changes and savings. *Telemedicine and e-Health, 21*(7), 533–537.
- Ingoldsbey, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies, 19*(5), 629–645.
- Jackson Foster, L. J., Phillips, C. M., Yabes, J., et al. (2015). Childhood behavioral

- disorders and trauma: Predictors of comorbid mental disorders among adult foster care alumni. *Traumatology*, 21(3), 119.
- Kataoka, S. H., Podell, J. L., Zima, B. T., et al. (2014). MAP as a model for practice-based learning and improvement in child psychiatry training. *Journal of Clinical Child and Adolescent Psychology*, 43(2), 312–322.
- Kazak, A. E., Hoagwood, K., Weisz, J. R., et al. (2010). A meta-systems approach to evidence-based practice for children and adolescents. *The American Psychologist*, 65(2), 85–97.
- Kroenke, K., & Unutzer, J. (2017). Closing the false divide: Sustainable approaches to integrating mental health services into primary care. *Journal of General Internal Medicine*, 32(4), 404–410.
- Lester, P., Liang, L., Milburn, N., et al. (2016). Evaluation of a family-centered preventive intervention for military families: Parent and child longitudinal outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*, 55(1), 14–24.
- Lindsey, M. A., Brandt, N. E., Becker, K. D., et al. (2014). Identifying the common elements of treatment engagement interventions in children's mental health services. *Clinical Child and Family Psychology Review*, 17(3), 283–298.
- McCarron, R. M., Bourgeois, J. A., Chwastiak, L. A., et al. (2015). Integrated medicine and psychiatry curriculum for psychiatry residency training: A model designed to meet growing mental health workforce needs. *Academic Psychiatry*, 39(4), 461–465.
- McHugh, P. R., & Slavney, P. R. (2009). *The perspectives of psychiatry* (2nd ed.). John Hopkins University Press.
- McIntyre, A. (2000). Constructing meaning about violence, school, and community: Participatory action research with urban youth. *The Urban Review*, 32(2), 123–154.
- Mitchell, S. G., Gryczynski, J., O'Grady, K. E., et al. (2013). SBIRT for adolescent drug and alcohol use: Current status and future directions. *Journal of Substance Abuse Treatment*, 44(5), 463–472.
- National Council, Medical Directors Institute. *The psychiatric shortage: Causes and solutions.* (2017). Retrieved from <https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage-National-Council-.pdf> (Accessed on May 1, 2017).**
- Olin, S. S., Hoagwood, K. E., Rodriguez, J., et al. (2010). The application of behavior change theory to family-based services: Improving parent empowerment in children's mental health. *Journal of Child and Family Studies*, 19(4), 462–470.
- Olupeliyawa, A. M., O'Sullivan, A. J., Hughes, C., et al. (2014). The teamwork mini-clinical evaluation exercise (T-MEX): A workplace-based assessment focusing on collaborative competencies in health care. *Academic Medicine*, 89(2), 359–365.
- Osofsky, H. J., Speier, A., Hansel, T. C., et al. (2016). Collaborative health care and emerging trends in a community-based psychiatry residency model. *Academic Psychiatry*, 40(5), 747–754.
- Perlman, S., Willard, J., Herbers, J. E., et al. (2014). Youth homelessness: Prevalence and mental health correlates. *Journal of the Society for Social Work and Research*, 5(3), 361–377.
- Petering, R. (2016). Sexual risk, substance use, mental health, and trauma experiences of gang-involved homeless youth. *Journal of Adolescence*, 48, 73–81.
- Raney, L. E., Lasky, G. B., & Scott, C. (2017). *Integrated care: A guide for effective implementation*. American Psychiatric Pub.
- Ratzliff, A., Norfleet, K., Chan, Y., et al. (2015). Perceived educational needs of the integrated care psychiatric consultant. *Academic Psychiatry*, 39(4), 448–456.
- Reardon, C. L., Bentman, A., Cowley, D. S., et al. (2015). General and child and adolescent psychiatry resident training in integrated care: A survey of program directors. *Academic Psychiatry*, 39(4), 442–447.
- Repko, A. F., Szostak, R., & Buchberger, M. P. (2016). *Introduction to interprofessional studies*. Sage Publications.
- Rew, L., Powell, T., Brown, A., et al. (2017). An intervention to enhance psychological capital and health outcomes in homeless female youths. *Western Journal of Nursing Research*, 39(3), 356–373.
- Rowe, G. (2014). Psychometric properties of the new patients' expectations questionnaire. *Patient Experience Journal*, 1(1), 111–130.
- Rugen, K. W., Dolansky, M. A., Dulay, M., et al. (2018). Evaluation of Veterans Affairs primary care nurse practitioner residency: Achievement of competencies. *Nursing Outlook*, 66(1), 25–34.
- RWJ Foundation & Ashoka. *Well-being, part of a complete childhood.* (2016). Retrieved from: <https://medium.com/change-maker/wellbeing-part-of-a-complete-childhood-ef8a20b0f15d> (Accessed on May 1, 2017) .**
- Schwartz, R. H., O'Laughlen, M. C., & Kim, J. (2017). Survey to child/adolescent psychiatry and developmental/behavioral pediatric training directors to expand psychiatric-mental health training to nurse practitioners. *Journal of the American Association of Nurse Practitioners*, 29(6), 348–355.
- Shore, J. H. (2013). Telepsychiatry: Videoconferencing in the delivery of psychiatric care. *The American Journal of Psychiatry*, 170(3), 256–262.
- Stoner, A. M., Leon, S. C., & Fuller, A. K. (2015). Predictors of reduction in symptoms of depression for children and adolescents in foster care. *Journal of Child and Family Studies*, 24(3), 784.
- Traube, D. E., James, S., Zhang, J., & Landsverk, J. (2012). A national study of risk and protective factors for substance use among youth in the child welfare system. *Addictive Behaviors*, 37(5), 641–650.
- Warnick, E. M., Bearss, K., Weersing, V. R., et al. (2014). Shifting the treatment model: Impact on engagement in outpatient therapy. *Administration and Policy in Mental Health*, 41(1), 93–103.
- Weder, N., Zhang, H., Jensen, K., et al. (2014). Child abuse, depression, and methylation in genes involved with stress, neural plasticity, and brain circuitry. *Journal of the American Academy of Child and Adolescent Psychiatry*, 53, 417–424.
- Weisz, J. R., Kuppens, S., Eckshtain, D., et al. (2013). Performance of evidence-based youth psychotherapies compared with usual clinical care: A multilevel meta-analysis. *JAMA Psychiatry*, 70(7), 750–761.
- Wong, C. F., Clark, L. F., & Marlotte, L. (2016). The impact of specific and complex trauma on the mental health of homeless youth. *Journal of Interpersonal Violence*, 31(5), 831–854.
- Yuma-Guerrero, P. J., Lawson, K. A., Velasquez, M. M., et al. (2012). Screening, brief intervention, and referral for alcohol use in adolescents: A systematic review. *Pediatrics*, 130(1), 115–122.